Facility Services

This section contains payment policies and information for facility services.

All providers must follow the administrative rules, medical coverage decisions and payment policies contained within the *Medical Aid Rules and Fee Schedules* (MARFS), Provider Bulletins and Provider Updates.

If there are any services, procedures or text contained in the CPT® and HCPCS coding books that are in conflict with MARFS, the department's rules and policies take precedence (see WAC 296-20-010).

All policies in this document apply to claimants receiving benefits from the State Fund, the Crime Victims Compensation Program and self-insurers unless otherwise noted.

Questions may be directed to the Provider Hotline at 1-800-848-0811 or to the Crime Victims Compensation Program at 1-800-762-3716.

FACILITY SERVICES TABLE OF CONTENTS

HOSPITAL PAYMENT POLICIES

HOSPITAL PAYMENT POLICIES OVERVIEW

Insurers will pay for the costs of proper and necessary hospital services associated with an accepted industrial injury. Hospital payment policies established by the department are reflected in Chapters 296-20, 296-21, 296-23 and 296-23A WAC and in the Hospital Billing Instructions. No co-payments or deductibles are required or allowed from injured workers.

HOSPITAL BILLING REQUIREMENTS

All charges for hospital inpatient and outpatient services provided to injured workers must be submitted on the UB-92 billing form following the **UB-92 National Uniform Data Element Specifications.**

Hospitals are responsible for establishing criteria to define inpatient and outpatient services. All inpatient bills will be evaluated according to the department's Utilization Review Program. Inpatient bills submitted without a treatment authorization number may be selected for retrospective review.

For a current copy of the Hospital Billing Instructions, contact the Provider Hotline at 1-800-848-0811.

HOSPITAL ACQUISITION COST

Any item covered under the acquisition cost policy will be paid using the hospital-specific percent of allowed charges (POAC).

HOSPITAL INPATIENT PAYMENT INFORMATION

Self-Insured Payment Method

Services for hospital inpatient care provided to injured workers covered by the self-insured are paid using hospital-specific POAC factors for all hospitals (see WAC 296-23A-0210).

Crime Victims Compensation Program Payment Method

Services for hospital inpatient care provided to crime victims covered by the Crime Victims Compensation Program are paid using DSHS POAC factors (see WAC 296-30-090).

State Fund Payment Methods

Services for hospital inpatient care provided to injured workers covered by the State Fund are paid using three payment methods:

1. An All Patient Diagnosis Related Group (AP-DRG) system. See WAC 296-23A-0470 for exclusions and exceptions. The department currently uses AP-DRG Grouper version 21.0.
2. A statewide Per Diem rate for those AP-DRGs that have low volume or for inpatient services provided in Washington rural hospitals.
3. A Percent of Allowed Charges (POAC) for hospitals excluded from the AP-DRG system.

The following tables provide a summary of how the above methods are applied.

Hospital Type or Location	Payment Method for Hospital Inpatient Services
Hospitals not in Washington	Paid by an Out-of-State POAC factor. Effective **July 1, 2006** the rate is **53.8%.**
Washington excluded Hospitals: • Children's Hospitals • Health Maintenance Organizations (HMOs) • Military Hospitals • Veterans Administration • State Psychiatric Facilities	Paid 100% of allowed charges.
• Washington Major Teaching Hospitals; • Harborview Medical Center • University of Washington Medical Center	Paid on a per case basis for admissions falling within designated AP-DRGs.(1) For low volume AP-DRGs, Washington hospitals are paid using the statewide per diem rates for designated AP-DRG categories: • Chemical dependency • Psychiatric • Rehabilitation • Medical • Surgical
All other Washington Hospitals	Paid on a per case basis for admissions falling within designated AP-DRGs.(1) For low volume AP-DRGs, Washington hospitals are paid using the statewide per diem rates for designated AP-DRG categories: • Chemical dependency • Psychiatric • Rehabilitation • Medical • Surgical

(1) See http://www.LNI.wa.gov/ClaimsIns/Providers/Billing/default.asp under Fee Schedules for the current AP-DRG Assignment List.

Hospital Inpatient AP-DRG Base Rates

Effective **July 1, 2006** the AP-DRG Base Rates

Hospital	Base Rate
Harborview Medical Center	$10,000.44
University of Washington Medical Center	$9,442.62
All Other Washington Hospitals	$8,525.59

Hospital Inpatient AP-DRG Per Diem Rates

Effective **July 1, 2006** the AP-DRG Per Diem Rates are as follows:

Payment Category	Rate(1)	Definition
Psychiatric AP-DRG Per Diem	**$ 1,122.90** Multiplied by the number of days allowed by the department. Payment will not exceed allowed billed charges.	AP-DRGs 424-432
Chemical Dependency AP-DRG Per Diem	**$ 555.24** Multiplied by the number of days allowed by the department. Payment will not exceed allowed billed charges.	AP-DRGs 743-751
Rehabilitation AP-DRG Per Diem	**$ 1,451.82** Multiplied by the number of days allowed by the department. Payment will not exceed allowed billed charges.	AP-DRG 462
Medical AP-DRG Per Diem	**$ 1,687.00** Multiplied by the number of days allowed by the department. Payment will not exceed allowed billed charges.	AP-DRGs identified as medical
Surgical AP-DRG Per Diem	**$ 2,973.55** Multiplied by the number of days allowed by the department. Payment will not exceed allowed billed charges.	AP-DRGs identified as surgical

(1) For information on how specific rates are determined see Chapter 296-23A WAC at http://www.LNI.wa.gov/ClaimsIns/Rules/MedicalAid/default.asp The AP-DRG Assignment List with AP-DRG codes and descriptions and length of stay is in the fee schedules section and is available online at http://www.LNI.wa.gov/ClaimsIns/Providers/Billing/default.asp under Fee Schedules.

Additional Inpatient Hospital Rates

PAYMENT CATEGORY	RATE	DEFINITION
Transfer-out Cases	Unless the transferring hospital's charges qualify for low outlier status, the stay at this hospital is compared to the AP-DRGs average length of stay. If the patient's stay is less than the average length of stay, a per-day rate is established by dividing the AP-DRG payment amount by the average length of stay for the AP-DRG. Payment for the first day of service is two times the per-day rate. For subsequent allowed days, the basic per-day rate will be paid. If the patient's stay is equal to or greater than the average length of stay, the AP-DRG payment amount will be paid.	A transfer is defined as an admission to another acute care hospital within 7 days of a previous discharge.
Low Outlier Cases (costs are less than the threshold)	Hospital Specific POAC Factor multiplied by allowed billed charges.	Cases where the cost (1) of the stay is less than ten percent (10%) of the statewide AP-DRG rate or **$ 519.50**, whichever is greater.
High Outlier Cases (costs are greater than the threshold)	AP-DRG payment rate plus 100% of costs in excess of the threshold.	Cases where the cost (1) of the stay exceeds **$15,694.72** or two standard deviations above the statewide AP-DRG rate, whichever is greater.

(1) Costs are determined by multiplying the allowed billed charges by the hospital specific POAC factor.

HOSPITAL OUTPATIENT PAYMENT INFORMATION

Self-Insured Payment Method

Services for hospital outpatient care provided to injured workers covered by self-insured employers are paid using facility-specific POAC factors or the appropriate Professional Services Fee Schedule amounts (see WAC 296-23A-0221).

Crime Victims Compensation Program Payment Method

Services for hospital outpatient care provided to crime victims covered by the Crime Victims Compensation Program are paid using either DSHS POAC factors or the Professional Services Fee Schedule (see WAC 296-30-090).

State Fund Payment Methods

Services for hospital outpatient care provided to injured workers covered by the State Fund are paid using three payment methods:

1. Outpatient Prospective Payment System (OPPS) utilizing an Ambulatory Payment Classification (APC) system. See Chapter 296-23A WAC (Section 4), WACs 296-23A-0220, 296-23A-0700 through 296-23A-0780 and Provider Bulletins 01-13 and 02-05 for a description of the department's OPPS system.
2. An amount established through the department's Professional Services Fee Schedule for items not covered by the APC system.
3. POAC for hospital outpatient services not paid by either the APC system or with an amount from the Professional Services Fee Schedule.

The following table provides a summary of how the above methods are applied.

Hospital Type or Location	Payment Method for Hospital Outpatient Services
Hospitals not in Washington State	Paid by an Out-of-State POAC factor. Effective **July 1, 2006** the rate is **53.8%.**
Washington Excluded Hospitals: • Children's Hospitals • Military Hospitals • Veterans Administration • State Psychiatric Facilities	Paid 100% of allowed charges
• Rehabilitation Hospitals • Cancer Hospitals • Critical Access Hospitals • Private Psychiatric Facilities	Paid a facility-specific POAC or Fee Schedule amount depending on procedure
All other Washington Hospitals	Paid on a per APC (1) basis for services falling within designated APCs. For non-APC paid services, Washington hospitals are paid using an appropriate Professional Services Fee Schedule amount, or a facility-specific POAC(1).

(1) Hospitals will be sent their individual POAC and APC rate each year.

Pass-Through Devices

A transitional pass-through device is an item accepted for payment as a new, innovative medical device by CMS where the cost of the new device has not already been incorporated into an APC. Hospitals will be paid fee schedule or if no fee schedule exists, a hospital-specific POAC for new or current pass-through devices. New or current drug or biological pass-through items will be paid by fee schedule or POAC (if no fee schedule exists).

Hospital OPPS Payment Process

Question	Answer	Payment Method
1. Does L&I cover the service?	No	Do Not Pay
	Yes	Go to question 2
2. Does the service coding pass the Outpatient Code Editor (OCE) edits?	No	Do Not Pay
	Yes	Go to question 3
3. Is the procedure on the inpatient-only list?	No	Go to question 4
	Yes	Pay POAC(1)
4. Is the service packaged?	No	Go to question 5
	Yes	Do Not Pay, but total the Costs for possible outlier(2) consideration. Go to question 7.
5. Is there a valid APC?	No	Go to question 6
	Yes	Pay the APC amount and total payments for outlier(2) consideration. Go to question 7.
6. Is the service listed in a Fee Schedule?	No	Pay POAC
	Yes	Pay the Facility Amount for the service
7. Does the service qualify for outlier?(1)	No	No outlier payment
	Yes	Pay outlier amount (3)

(1) If only 1 line item on the bill is IP, the entire bill will be paid POAC.
(2) Only services packaged or paid by APC are used to determine outlier payments.
(3) Outlier amount is in addition to regular APC payments.

OPPS Relative Weights and Payment Rates

The relative weights used by CMS will be used for the OPPS program. Each hospital's blended per-APC rate was determined using a combination of the average hospital-specific per APC rate and the statewide average per APC rate. Additional information on the formulas used to establish individual hospital rates can be found in WAC 296-23A-0720. Hospitals will receive notification of their blended per-APC rate via separate letter from the department or by accessing http://www.LNI.wa.gov/ClaimsIns/Providers/Billing/FeeSched/2006/2006.asp and clicking on the hospital rates link.

OPPS Outlier Payments

The department follows the current CMS outlier payment policy. See the most current federal register for a complete description of the policy.

AMBULATORY SURGERY CENTER (ASC) PAYMENT POLICIES

ASC GENERAL INFORMATION

Information about the department's requirements for ASCs can be found in Chapter 296-23B WAC.

WHO MAY BILL FOR ASC SERVICES

An ASC is an outpatient facility where surgical services are provided and that meets the following three requirements:

1. Must be licensed by the state(s) in which it operates, unless that state does not require licensure;
2. Must have at least one of the following credentials:
    a. Medicare Certification as an ambulatory surgery center; or
    b. Accreditation as an ambulatory surgery center by a nationally recognized agency acknowledged by the Centers for Medicare and Medicare Services (CMS); and
3. Must have an active ambulatory surgery center provider account with the Department of Labor and Industries.

Only facilities that meet the above criteria may bill for ASC services.

BECOMING ACCREDITED OR MEDICARE CERTIFIED AS AN ASC

Providers may contact the following organizations for information:

National Accreditation

American Association for Accredtitation of Ambulatory Surgery Facilities
5101 Washington Street, Suite #2F
PO BOX 9500 Gurnee, IL 60031
888-545-5222; Web: www.aaaasf.org

Accreditation Association for Ambulatory Health Care
3201 Old Glenview Rd., Suite 300
Wilmette, IL 60091
847-853-6060; Web: www.aaahc.org

American Osteopathic Association
142 East Ontario Street
Chicago, IL 60611
800-621-1773; Web: www.osteopathic.org

Commission on Accreditation of Rehabilitation Facilities
4891 East Grant Road
Tucson, AZ 85712
888-281-6531; Web: www.carf.org

Joint Commission on Accreditation of Healthcare Organizations
One Renaissance Blvd.
Oakbrook Terrace, IL 60181
630-792-5862; Web: www.jcaho.org

Medicare Certification

Department of Health
Office of Health Care Survey
Facilities and Services Licensing
PO BOX 47852
Olympia, WA 98504-7852
360-236-2905; e-mail: fslhhhacs@doh.wa.gov
Web: www.doh.wa.gov/hsqa/fsl/HHHACS_home.htm

Please note it may take 3-6 months to get certification or accreditation.

ASC PAYMENTS FOR SERVICES

The insurer pays the lesser of the billed charge (the usual and customary fee) or the department's maximum allowed rate.

The department's rates are based on a modified version of the grouping system developed by Medicare for ASC services. Medicare's grouping system was originally intended to group procedures with similar resource use together into payment categories. The department has modified Medicare's grouping system to fit a workers' compensation population. Surgical services have been divided into 14 payment groups, each with an associated maximum fee.

ASC Services Included in the Facility Payment

Facility payments for ASCs include the following services which are not paid separately:

- Nursing, technician and related services.
- Use by the recipient of the facility including the operating room and the recovery room.
- Drugs, biologics, surgical dressings, supplies, splints, casts and appliances and equipment directly related to the provision of surgical procedures.
- Diagnostic or therapeutic services or items directly related to the provision of a surgical procedure.
- Administration, record keeping and housekeeping items and services.
- Intraocular lenses.
- Materials for anesthesia.
- Blood, blood plasma and platelets.

ASC Services Not Included in the Facility Payment

Facility payments for ASCs do not include the following services which are paid separately:

- Professional services including physicians.
- Laboratory services.
- X-Ray or diagnostic procedures other than those directly related to the performance of the surgical procedure.
- Prosthetics and implants except intraocular lenses.
- Ambulance services.
- Leg, arm, back and neck braces.
- Artificial limbs.
- DME for use in the patient's home.

ASC Procedures Covered For Payment

The department uses the CMS list of procedures covered in an ASC plus additional procedures determined to be appropriate. All procedures covered in an ASC are listed in the Provider Billing and Fees, Fee Schedules section available online at: http://www.LNI.wa.gov/ClaimsIns/Providers/Billing/default.asp.

The department expanded the list that CMS established for allowed procedures in an ASC. There are three areas where the list has been expanded:

1. L&I will cover surgical procedures that other Washington State agencies cover in ASCs and that meet L&I's coverage policies.
2. L&I will cover surgical procedures that CMS covers in its hospital outpatient prospective payment system (OPPS) that are not on the CMS ASC list and that meet L&I's coverage policies.
3. L&I will cover some procedures in an ASC that CMS covers only in an inpatient setting if both of the following criteria are met:
    a. The surgeon deems that it is safe and appropriate to perform such a procedure in an outpatient setting and
    b. The procedure meets the department's utilization review requirements.

ASC Procedures Not Covered For Payment

Procedures that are not listed in the ASC fee schedule section of MARFS are not covered in an ASC.

ASCs will not receive payment for facility services for minor procedures that are commonly done in an office setting or treatment room. See the next paragraph for exceptions to this policy. The provider performing these procedures may still bill for the professional component.

Process to Obtain Approval for a Non-Covered Procedure

Under certain conditions, the director, the director's designee or self-insurer, at their sole discretion, may determine that a procedure not on the department's ASC procedure list may be authorized in an ASC. For example, this may occur when a procedure could be harmful to a particular patient unless performed in an ASC. Requests for coverage under these special circumstances require prior authorization.

The health care provider must submit a written request and obtain approval from the insurer prior to performing any procedure not on the ASC procedure list. The written request must contain a description of the proposed procedure with associated CPT® or HCPCS procedure codes, the reason for the request, the potential risks and expected benefits and the estimated cost of the procedure. The healthcare provider must provide any additional information about the procedure requested by the insurer.

ASC BILLING INFORMATION

Modifiers Accepted for ASCs

–SG Ambulatory Surgical Center facility service

Modifier –SG may accompany all CPT® and HCPCS codes billed by an ASC. The insurer will accept modifiers listed in the CPT® and HCPCS books including those listed as approved for ASCs.

Modifiers Affecting Payment for ASCs

–50 Bilateral modifier

Modifier –50 identifies cases where a procedure typically performed on one side of the body is performed on both sides of the body during the same operative session. Providers must bill using separate line items for each procedure performed. Modifier –50 must be applied to the second line item. The second line item will be paid at **50%** of the allowed amount for that procedure.

Example: Bilateral Procedure

Line item on bill	CPT® code/modifier	Maximum payment (Group 2)	Bilateral policy applied	Allowed amount
1	64721 –SG	$ 1,011.00		$ 1,011.00(1)
2	64721 –SG –50	$ 1,011.00	$ 505.50(2)	$ 505.50
Total allowed amount				$ **1,516.50**(3)

(1) First line item is paid at 100% of maximum allowed amount.
(2) When applying the bilateral payment policy the second line item billed with a modifier –50 is paid at 50% of the maximum allowed amount for that line item.
(3) Represents total allowable amount.

–51 Multiple Surgery

Modifier –51 identifies when multiple surgeries are performed on the same patient at the same operative session. Providers must bill using separate line items for each procedure performed. Modifier –51 should be applied to the second line item. The total payment equals the sum of:

100% of the maximum allowable fee for the highest valued procedure according to the fee schedule, plus

50% of the maximum allowable fee for the subsequent procedures with the next highest values according to the fee schedule.

Example: Multiple Procedures

Line item on bill	CPT® code/modifier	Maximum payment (Groups 4 & 2)	Multiple policy applied	Allowed amount
1	29881 –SG	$ 1,429.00		$ 1,429.00(1)
2	64721 –SG –51	$ 1,011.00	$ 505.50(2)	$ 505.50
Total allowed amount				$ **1934.50**(3)

(1) Highest valued procedure is paid at 100% of maximum allowed amount.
(2) When applying the multiple procedure payment policy the second line item billed with a modifier –51 is paid at 50% of the maximum allowed amount for that line item.
(3) Represents total allowable amount.

If the same procedure is performed on multiple levels the provider must bill using separate line items for each level.

Example: Bilateral Procedure and Multiple Procedures

Line Item	CPT® Code/Mod	Max Payment (Group 11)	Bilateral Applied	Multiple Applied	Allowed Amount
1	63042 –SG	$3,226.84			$3,226.84. (1)
2	63042 –SG –50	$3,226.84	$1,613.42 (2)		$1,613.42
					Subtotal $4,840.26 (3)
3	22612 –SG –51	$3,226.84		$ 1,613.42(4)	$1,613.42
Total Allowed Amount in Non-Facility Setting:					**$6,453.68** (5)

(1) Allowed amount for the highest valued procedure is the fee schedule maximum.
(2) When applying the bilateral payment policy, the two line items will be treated as one procedure. The second line item billed with a modifier –50 is paid at 50% of the value paid for the first line item.
(3) The combined bilateral allowed amount is used to determine the highest valued procedure when applying the multiple surgery rule.
(4) The third line item billed with modifier –51 is paid at 50% of the maximum payment.
(5) Represents total allowable amount.

–73 Discontinued procedures prior to the administration of anesthesia

Modifier –73 is used when a physician cancels a surgical procedure due to the onset of medical complications subsequent to the patient's preparation, but prior to the administration of anesthesia. Payment will be at **50%** of the maximum allowable fee. Multiple and bilateral procedure pricing will apply to this, if applicable.

–74 Discontinued procedures after administration of anesthesia

Modifier –74 is used when a physician terminates a surgical procedure due to the onset of medical complications after the administration of anesthesia or after the procedure was started. Payment will be at **100%** of the maximum allowable fee. Multiple and bilateral procedure pricing will apply to this, if applicable.

–99 Multiple modifiers

Modifier –99 must be used when more than four modifiers affect payment. Payment is based on the policy associated with each individual modifier that describes the actual services performed. For billing purposes only modifier –99 must go in the modifier column, with the individual descriptive modifiers that affect payment listed in the remarks section of the billing form.

Exception: **Procedure Codes assigned to ASC Payment Groups 12 and 14**

CPT® and HCPCS codes assigned to ASC Payment Group 12 and ASC Payment Group 14 are not subject to multiple procedure discounting. A listing of the codes and payment groups are available online at http://www.LNI.wa.gov/ClaimsIns/Providers/Billing/default.asp under Fee Schedules.

Prosthetic Implants

Implants must be billed on a separate line. The department covers various HCPCS implant codes in the range L8500 through L8699, V2630 through V2632 and the corneal processing code V2785. Each code pays the lesser of the maximum fee or acquisition cost. See the current ASC Fee Schedule for the specific codes the department covers in this range.

Exception: Intraocular Lenses

Intraocular lenses, including new technology lenses, are bundled into the fee for the associated procedure. Please include the cost of the lens in the charge for the procedure. It is permissible to include a line on the bill with the HCPCS code for an intraocular lens (i.e., V2630, V2631 and V2632) and its associated cost for information purposes only.

Acquisition Cost Policy

The acquisition cost equals the wholesale cost plus shipping, handling and sales tax. These items must be billed together as one charge. For taxable items, an itemized listing of the cost plus sales tax may be attached to the bill but is not required.

Wholesale invoices for all supplies and materials must be retained in the provider's office files for a minimum of five years. A provider must submit a hard copy of the wholesale invoice to the insurer when an individual supply costs $150.00 or more, or upon request. The insurer may delay payment of the provider's bill if the insurer has not received this information.

Example: Procedure with Implant

Line item on bill	CPT® code/modifier	Maximum payment (Group 4)	Allowed amount
1	29851 –SG	$ 1,429.00	$ 1,429.00(1)
2	L8699	$ 150.00 (Acquisition cost)	$ 150.00(2)
Total allowed amount			$ **1,579.00**(3)

(1) Procedure is paid at 100% of maximum allowed amount.
(2) Represents the total of wholesale implant cost plus associated shipping, handling and taxes.
(3) Represents total allowable amount.

Spinal Injections

Injection procedures are billed in the same manner as all other surgical procedures with the following considerations:

1. For the purpose of multiple procedure discounting, each procedure in a bilateral set is considered to be a single procedure.
2. For injection procedures which require the use of radiographic localization and guidance, ASCs must bill for the technical component of the radiologic CPT® code (e.g., 76005 –TC) to be paid for the operation of a fluoroscope or C-arm.
3. Maximum fees for the technical components of the radiologic CPT® codes are listed in the radiology section of the Professional Services Fee Schedule available online at: http://www.LNI.wa.gov/ClaimsIns/Providers/Billing/default.asp under Fee Schedules.

Example: Injection Procedures

Line item on bill	CPT® code/modifier	Maximum payment (Groups 1 &14)	Bilateral/Multiple policies applied	Allowed amount
1	64470 –SG	$ 755.00		$ 755.00(1)
2	64470 –SG –50	$ 755.00	$ 377.50(2)	$ 377.50
3	64472 –SG	$ 755.00	$ 377.50(3)	$ 377.50
4	64472 –SG –50	$ 755.00	$ 377.50(2)	$ 377.50
5	76005 –TC	$ 75.91		$ 75.91(4)
Total allowed amount				**$1,963.41**(5)

(1) Highest valued procedure is paid at 100% of maximum allowed amount.
(2) When applying the bilateral procedure payment policy the second line item billed with a modifier –50 is paid at 50% of the maximum allowed amount for that line item.
(3) The multiple procedure payment policy is applied to subsequent procedures billed on the same day and are paid at 50% of the maximum allowed amount for that line item.
(4) This is the fee schedule maximum allowed amount for the fluoroscopic localization and guidance.
(5) Represents total allowable amount.
Note: ASCs may use modifier –SG with HCPCS code G0260. The insurer will only pay one unit per day to an ASC.

ASC Maximum Allowable Fee by Group Number (1)(2)

Group	Fee	Payment Method
1	$ 755.00	Fee Based on Medicare Rate
2	$1,011.00	Fee Based on Medicare Rate
3	$1,156.00	Fee Based on Medicare Rate
4	$1,429.00	Fee Based on Medicare Rate
5	$1,626.00	Fee Based on Medicare Rate
6	$1,719.00	Fee Based on Medicare Rate
7	$2,309.00	Fee Based on Medicare Rate
8	$2,060.00	Fee Based on Medicare Rate
9	$3,036.00	Fee Based on Medicare Rate
10	$5,089.00	Max Fee, CPT® Code 63030
11	Max Fee	Codes allowed in APC not on ASC List
12	Acquisition Cost or Bundled	AC or Bundled
13	By Report	BR – Codes considered inpatient by CMS
14	Max Fee	Max Fee (e.g., CPT® Codes 72240, 76005 or L8603), Radiology.

(1) Some services that do not belong to a payment group have a maximum fee. Other allowed services that are not part of a payment group are paid by report (BR) or by the acquisition cost (AC) policy.
(2) Payment groups and rates for allowed procedures are listed in the ASC Fee Schedule.

BRAIN INJURY REHABILITATION SERVICES

QUALIFYING PROVIDERS

Only providers accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF) may provide post-acute brain injury rehabilitation services for injured workers. The department requires a provider rendering treatment on a State Fund claim to submit proof of their CARF accreditation to:

Department of Labor & Industries
Provider Accounts Unit
PO Box 44261
Olympia, WA 98504-4261

Special L&I Provider Number required

Providers who have not already obtained a special provider number for their CARF accredited post-acute brain injury rehabilitation program must apply with the department for a provider number in order to bill the department for these services. Providers may request a provider application or determine if they already have a qualifying provider number by calling the toll free Provider Hotline at 1-800-848-0811 or downloading provider application form from the L&I web site at http://www.LNI.wa.gov/forms/pdf/248011a0.pdf.

Note: Providers billing for State Fund claims must bill brain injury rehabilitation services using the special post-acute brain injury rehabilitation program provider number assigned by the department.

QUALIFYING PROGRAMS

Post-acute brain injury rehabilitation programs must include the following phases:

- Evaluation
- Treatment
- Follow-up

AUTHORIZATION REQUIREMENTS

Post-acute brain injury rehabilitation evaluation and treatment require prior authorization by a claims unit ONC. They ensure the level of care and the amount of care requested are appropriate and related to the industrial injury. The claims unit ONCs are available to assist the rehabilitation programs with the referral process.

Cases requiring post-acute brain injury rehabilitation will be reviewed by the ONCs prior to making a determination or authorization. Contact the claims unit ONCs at (360) 902-5013.

All services also require prior authorization by the Claim Manager after review by a claims unit ONC.

Approval Criteria

For an injured worker to receive treatment in a post-acute brain injury rehabilitation program all of the following conditions must be met:

- The insurer has allowed brain injury as an accepted condition under the claim; and
- The brain injury is related to the industrial injury or is retarding recovery; and
- The worker is physically, emotionally, cognitively and psychologically capable of full participation in the rehabilitation program; and
- The screening evaluation done by the brain injury program demonstrates the worker is capable of new learning following the brain injury; and
- The screening evaluation report by the program identifies specific goals to help the worker improve function or accommodate for lost function.

Comprehensive Brain Injury Evaluation Requirements

A Comprehensive Brain Injury Evaluation must be performed for all injured workers who are being considered for admission for inpatient services or into an outpatient post-acute brain injury rehabilitation treatment program. This type of evaluation is multidisciplinary and contains an in-depth analysis of the injured workers mental, emotional, social and physical status and functioning.

The evaluation must be provided by a multidisciplinary team that includes a medical physician, psychologist, vocational rehabilitation specialist, physical therapist, occupational therapist, speech therapist and neuropsychologist. Additional medical consultations are referred through the program's physician. Each consultation may be billed under the provider number of the consulting physician and must be pre-authorized by a claims unit ONC.

BILLING INFORMATION

Tests Included in the Comprehensive Brain Injury Evaluation

The following list of tests and services are included in the price of performing a Comprehensive Brain Injury Evaluation and may be performed in any combination as is indicated by the injured workers condition (these services cannot be billed separately):

- Neuropsychological Diagnostic Interview(s), testing and scoring.
- Initial consultation and examination with the programs physician.
- Occupational and Physical Therapy evaluations.
- Vocational Rehabilitation evaluation.
- Speech and language evaluation.
- Comprehensive report.

Preparatory Work Included in the Comprehensive Brain Injury Evaluation

The complementary and/or preparatory work that may be necessary to complete the Comprehensive Brain Injury Evaluation is considered part of the provider's administrative overhead. It includes but is not limited to:

- Obtaining and reviewing the injured worker's historical medical records; and
- Interviewing family members, if applicable; and
- Phone contact and letters to other providers or community support services; and
- Writing the final report; and
- Office supplies and materials required for service(s) delivery.

Therapies Included in the Treatment

The following therapies, treatments and/or services are included in the maximum fee schedule amount for the full-day or half-day brain injury rehabilitation treatment and may not be billed separately:

- Physical therapy and occupational therapy.
- Speech and language therapy.
- Psychotherapy.
- Behavioral modification and counseling.
- Nursing and health education and pharmacology management.
- Group therapy counseling.
- Activities of daily living management.
- Recreational therapy (including group outings).
- Vocational counseling.
- Follow-up interviews with injured worker or family, which may include home visits and phone contacts.

Preparatory Work Included in Treatment

Ancillary work, materials and preparation that may be necessary to carry out program functions and services that are considered part of the provider's administrative overhead and are not payable separately include, but are not limited to:

- Daily charting of patient progress and attendance.
- Report preparation.
- Case management services.
- Coordination of care.
- Team conferences and interdisciplinary staffing.
- Educational materials (e.g., work books and tapes).

Follow-up Included in Treatment

Follow-up care is included in the cost of the full-day or half-day program. This includes but is not limited to telephone calls, home visits and therapy assessments.

DOCUMENTATION REQUIREMENTS

The following documentation is required of providers when billing the department for post-acute brain injury rehabilitation treatment programs:

- Providers are required to keep a daily record of an injured workers attendance, activities, treatments and progress.
- All test results and scoring must also be kept in the injured worker's medical record. Records should also include documentation of interviews with family and any coordination of care contacts (e.g., phone calls and letters) made with providers or case managers not directly associated with the facilitiy's program.
- Progress reports should be sent to the department regularly, including all pre-admission and discharge reports.

FEES

Non-Hospital Based Programs

The following are the local codes and payment amounts for non-hospital based outpatient post-acute brain injury rehabilitation treatment programs.

Code	Description	Maximum Fee
8950H	Comprehensive brain injury evaluation	$ 3,869.03
8951H	Post-acute brain injury rehabilitation full day program, per day (minimum of 6 hours per day)	$ 690.89
8952H	Post-acute brain injury rehabilitation half day program, per day (minimum 4 hours per day)	$ 414.55

Hospital Based Programs

The following are the revenue codes and payment amounts for hospital based outpatient post-acute brain injury rehabilitation treatment programs.

Code	Description	Maximum Fee
0014	Comprehensive brain injury evaluation	$ 3,869.03
0015	Post-acute brain injury rehabilitation full day program, per day (minimum of 6 hours per day)	$ 690.89
0016	Post-acute brain injury rehabilitation half day program, per day (minimum 4 hours per day)	$ 414.55

NURSING HOME, RESIDENTIAL AND HOSPICE CARE SERVICES

COVERED SERVICES

The insurer covers proper and necessary residential care services consisting of 24-hour institutional care that meet the injured worker's needs, abilities and safety. The insurer will also cover medically necessary hospice care comprising of skilled nursing care and custodial care for the worker's accepted industrial injury or illness.

Prior authorization is required by an L&I Claims Unit Occupational Nurse Consultant (ONC) or the self-insured employer.

Services must be:

- Proper and necessary; and
- Required due to an industrial injury or occupational disease; and
- Requested by the attending physician; and
- Authorized by an L&I claims unit ONC before care begins.

Facilities

DSHS-licensed facilities providing residential services comprising 24-hour institutional care with an active L&I provider account number including:

- Skilled Nursing Facilities (SNF).
- Nursing Homes (NH) licensed by the Department of Social and Health Services (DSHS).
- Transitional Care Units (TCU) that are independent and licensed by DOH or who are doing business as part of a Nursing Home or Hospital and are covered by the license of the Nursing Home or Hospital.
- Adult Family Homes certified by DSHS.
- Boarding Homes licensed by DSHS.
- DSHS-licensed hospice care providers.

For State Fund claims, providers must obtain a separate provider account number from L&I for each type of service performed. Obtain the necessary forms at http://www.LNI.wa.gov/forms/pdf/248011a0.pdf

NON-COVERED SERVICES

Services in assisted living facilities are not covered by the department.

AUTHORIZATION REQUIREMENTS

Initial Admission

Only L&I Claims Unit Occupational Nurse Consultants (ONCs) can authorize residential care services for State Fund claims. The Claims Unit ONC and the admissions coordinator of the facility discuss the care needs of the injured worker, and the Claims Unit ONC authorizes an initial length of stay. Contact the Claims Unit ONCs at (360)902-5013.

All State Fund residential care services require prior authorization. To receive payment, providers are responsible for notifying the department when they agree to provide residential care services for an injured worker. For authorization procedures on a self-insured claim, contact the self-insurer directly.

Nursing facilities and transitional care units providing care for a State Fund claim injured worker must complete the most current version of the Minimum Data Set (MDS) Basic Assessment Tracking Form (available from the Centers for Medicare and Medicaid Services at http://www.cms.hhs.gov/medicaid/mds20/man-form.asp for the injured worker within ten working days of admission. This form or similar instrument will also determine the appropriate L&I payment group.

Failure to assess the injured worker and to report the appropriate payment group to an L&I Claims Unit ONC may result in delayed or reduced payment. This requirement applies to all lengths of stay.

When Care Needs Change

For State Fund claims, if the care needs of injured workers admitted on or after January 1, 2005 change, a new assessment must be completed and communicated to an L&I Claims Unit ONC. If the initial length of stay needs to be extended, or if the severity of the injured worker's condition changes, providers must contact an L&I Claims Unit ONC for re-authorization of the injured worker's care.

For policies regarding changes in the care needs of self-insured claims, contact the self-insurer directly.

BILLING INFORMATION

Billing Requirements

Providers who are treating State Fund injured workers prior to January 1, 2005 will have their negotiated arrangements continue until the injured workers' need for those services ends or until the injured worker is admitted to a new facility. In such cases, providers may continue using code 8902H for the remainder of the time the injured worker is treated.

Providers beginning treatment on a State Fund claim on or after January 1, 2005 will utilize the fee schedule or new daily rates appropriate for the type of facility providing treatment and must meet other requirements outlined in this section. For billing, payment and record keeping requirements on self-insured claims, contact the self-insurer directly.

Billing Rules

The primary billing procedures for State Fund claims applicable to residential facility providers can be found in WAC 296-20-125, Billing procedures.

Billing Forms

All State Fund Residential Care Services should be billed on form F245-072-000 Statement for Miscellaneous Services found at http://www.LNI.wa.gov/Forms/pdf/245072af.pdf.

Documentation and Record Keeping Requirements

See Documentation Requirements in the Introduction section.

Pharmaceuticals and Durable Medical Equipment

Only pharmacies can bill for pharmaceuticals on State Fund claims. Special Durable Medical Equipment (DME) and pharmaceuticals required to treat the injured worker's accepted condition on State Fund claims must be billed separately to the department. For billing procedures on self-insured claims, contact the self-insurer directly.

Billing Tip

Inappropriate use of CPT® and HCPCS codes may delay payment. For example, billing drugs or physical therapy using DME codes is improper coding and will delay payment while the claim is being investigated.

DEPARTMENTAL REVIEW OF RESIDENTIAL SERVICES

The department or its designee may perform periodic independent nursing evaluations of residential care services provided to State Fund injured workers. Evaluations may include, but are not limited to, on-site review of the injured worker and review of medical records. For review procedures on a self-insured claim, contact the self-insurer directly.

All services rendered to injured workers for State Fund claims are subject to audit by the department as instructed by the legislature in RCW 51.36.100 and RCW 51.36.110.

FEES

Negotiated payment arrangements

Self-insured and State Fund claims with existing negotiated arrangements:

Code	Description	Maximum Fee
8902H	Negotiated payment arrangements	By Report

Note: Providers with existing negotiated arrangements for State Fund claims prior to January 1, 2005 may continue their current arrangements and continue to bill using code 8902H for the remainder of time the injured worker is treated unless the injured workers need for services no longer exists or the injured worker is transferred to a new facility.

Hospice Care

Daily rate fees are negotiated between the facility and the insurer based on the Medicare rates for services provided. Occupational, physical and speech therapies are included in the daily rate and are not separately payable. Pharmacy and DME are payable when billed separately using appropriate HCPCS codes.

Programs must bill the following local codes:

Code	Description	Maximum Fee
8906H	Facility hospice care	By Report

Boarding Homes and Adult Family Homes

Billing codes and payment rates for State Fund claims.

Self-Insured Claims: Self-insurers will negotiate rates. Contact the self-insurer directly.

Code	Description	Maximum Fee
8891H	Adult family home residential care for injured worker (per day)	$ 220.90

Code	Description	Maximum Fee
8892H	Boarding home residential care for injured worker (per day)	$ 120.90

Nursing Home and Transitional Care Unit Fees

The department used a modified version of the skilled nursing facility prospective payment system, developed by the Centers for Medicare and Medicaid Services, as a basis for developing the L&I residential facility payment system.

The fee schedule for NHs and TCUs is a series of daily facility payment rates including room rate, therapies and nursing components depending on the needs of the injured worker. Medications are not included in the L&I rate. The L&I rate applies to State Fund claims only.

Self-Insured Claims: Self-insurers will negotiate rates. Contact the self-insurer directly.

For State Fund Claims:

FEE SCHEDULE – NURSING HOMES & TRANSITIONAL CARE UNITS Effective 07/01/06

Self-Insured Claims: Self-insurers will negotiate rates. Contact the self-insurer directly.

Code	Description	Included Medicare Rug Codes	Maximum Fee
8880H	Rehab-Ultra High	RUX, RUL, RUC, RUB, RUA	$ 590.10
8881H	Rehab-Very High	RVX, RVL, RVC, RVB, RVA	$ 442.46
8882H	Rehab-High	RHX, RHL, RHC, RHB, RHA	$ 378.65
8883H	Rehab-Medium	RMX, RML, RMC, RMB, RMA	$ 417.24
8884H	Rehab-Low	RLX, RLB, RLA	$ 300.04
8885H	Extensive Services	SE3, SE2, SE1	$ 373.77
8886H	Special Care	SSC, SSB, SSA	$ 278.42
8887H	Clinically Complex	CC2, CC1, CB2, CB1, CA2, CA1	$ 276.90
8888H	Impaired Cognition	IB2, IB1, IA2, IA1	$ 204.26
8889H	Behavior Only	BB2, BB1, BA2, BA1	$ 202.74
8890H	Reduced Physical Function	PE2, PE1, PD2, PD1, PC2, PC1, PB2, PB1, PA2, PA1	$ 220.90

CHRONIC PAIN MANAGEMENT PROGRAM PAYMENT POLICIES

GENERAL INFORMATION

Information about the department's requirements for Chronic Pain Management Program can be found in Provider Bulletin 04-15, available online line at

http://www.LNI.wa.gov/ClaimsIns/Providers/Billing/ProvBulletins/default.asp

Eligibility Requirements

In order to be eligible to provide chronic pain management program services to injured workers, the Commission on Accreditation of Rehabilitation Facilities (CARF) must accredit the provider as an interdisciplinary pain rehabilitation program.

The term interdisciplinary is meant to describe the type of program and is not meant to define the practice skills of staff members. It is the department's expectation that providers of chronic pain management program services work within the scope of practice for their specialty and/or be appropriately certified or licensed for the field in which they work (i.e., biofeedback technician maintains certification, nurse maintains current license, vocational rehabilitation counselor maintains department registration, licensed psychologist/psychiatrist supervise and interpret psychological testing, licensed medical providers supervise medical management).

Providers must maintain their CARF accreditation and provide the department with documentation of satisfactory recertification. The respective provider account will be inactivated if CARF accreditation expires. It is the provider's responsibility to notify the department when an accreditation visit is delayed for administrative reasons.

When A CARF Accredited Provider Is Not Reasonably Available

In certain circumstances, a CARF accredited provider may not be reasonably available for injured workers who have moved out of Washington State. In those circumstances, a provider with CARF-like credentials may provide chronic pain management program services to the injured worker.

For outpatient services, these CARF-like credentials include:

- Patient pre-screening is conducted by a physician, psychiatrist/psychologist, physical/occupational therapist, and a vocational rehabilitation counselor at a minimum.
- Regular interface occurs between a physician and the injured worker on a frequent if not daily basis during treatment.
- Treatment includes, at a minimum, medical management, psychiatric testing and/or counseling, physical and occupational therapy, and, if indicated, vocational rehabilitation services with return to work goals as indicated.
- Follow-up includes remedial treatment or status checks to determine how well the injured worker is coping following completion of their treatment.

For inpatient services, these CARF-like credentials include:

- The outpatient services credentials listed above, and
- Affiliation with a Joint Commission on Accreditation of Healthcare Organizations (JCAHO) accredited hospital.

CARF-like providers will be required to comply with the chronic pain management program policies and fee schedule as well as meet the same reporting requirements as CARF accredited programs. CARF-like providers must also obtain a department provider account number. The provider account number for CARF-like providers will be activated for only nine (9) months

Chronic Pain Management Phases

A chronic pain management program has an interdisciplinary team that provides appropriate services to rehabilitate persons with chronic pain. Multiple modalities address the psychosocial and cognitive aspects of chronic pain behavior together with physical rehabilitation.

A chronic pain management program consists of three phases with a separate fee for each phase.

The chronic pain management program phases are defined as:

- Evaluation Phase
    - This phase consists of an initial evaluation including at a minimum a medical examination, psychological evaluation, and a vocational assessment.
    - A summary evaluation report is required and must include information from each discipline participating in the evaluation and a return to work action plan if indicated.
    - This phase lasts one to two days.
- Treatment Phase
    - At a minimum, this phase consists of medical management, psychiatric testing and/or counseling, physical and occupational therapy, and vocational rehabilitation services with return to work goals if vocational issues have been identified. Other services provided in this phase may vary as required by the need of the injured worker.
    - A discharge report is required and must include the findings of each discipline involved in the treatment phase and must list the outcome of the treatment.
    - The maximum duration of this phase is 18 treatment days. The 18 treatment days are consecutive (excluding weekends and holidays). Each treatment day lasts 6-8 hours.
- Follow-Up Phase
    - This phase consists of remedial treatment or status checks as needed to determine how well the injured worker is coping following completion of the treatment phase. The goal is to extend and reinforce the gains made during the treatment phase. This phase is not a substitute for and cannot serve as a second treatment phase.
    - A follow-up report is required including the findings of all disciplines involved in providing the follow-up services.
    - This phase will last for no more than a total of five follow-up days during the three months immediately following completion of the treatment phase or treatment phase extension (information about the treatment phase extension is provided under the *Treatment Phase Extension Criteria* heading next in this subsection).

The reports required for each phase must be sent to the department and to the attending physician. When requested, other reports (i.e., weekly updates) may be required.

The fee schedule and procedure codes for these phases are listed in the following tables. This fee schedule applies to injured workers in either an outpatient or inpatient program.

Outpatient chronic pain management programs will bill using the local codes listed in the following table on a CMS - 1500 (HCFA) form. These fees may be adjusted annually when the department publishes its fee schedule.

Treatment Phase Extension Criteria

The claim manager can authorize up to 10 additional days of treatment for the injured worker.

Before the claim manager authorizes the treatment phase extension, one or both of the following criteria must be documented in the extension request:

1. Treatment is steadily progressing toward achievement of a treatment goal and how the extension supports meeting that specific treatment goal.
2. The injured worker is nearing completion of treatment and needs a few more sessions to achieve the treatment goal.

The following factors will be applied when evaluating a request for extending treatment:

1. The treatment phase extension is limited to a one-time basis per referral.
2. The extension should be on an outpatient basis. Extension of inpatient services will require concurrence of the respective claims unit ONC based on their review of the extension request and claim file.
3. Extensions are not granted for either the evaluation or follow-up phases.
4. The extension is limited to a specific number of treatment days not to exceed a maximum of 10 consecutive treatment days (excluding weekends and holidays). The start and end dates must be defined prior to start of the treatment phase extension.
5. The treatment phase extension request must be based on specific issues requiring further treatment. The request must be supported by documentation of progress made to date in the program.
6. The request must clearly state the goals of the treatment phase extension and time needed to meet those goals.

RETURN TO WORK ACTION PLAN

If the injured worker needs assistance in returning to work or becoming employable, the claim manager will authorize admission to the chronic pain management program for treatment after:

- The chronic pain management program vocational specialist (program counselor) and the department assigned vocational rehabilitation counselor (department assigned counselor) have agreed upon a return to work action plan with a return to work goal acceptable to the department, and
- The attending provider (AP) and the injured worker approve the return to work action plan with a return to work goal.

The return to work action plan is to provide the focus for vocational services during an injured worker's participation in a chronic pain management program. The initial plan is to be submitted with the evaluation report. The department assigned counselor will facilitate the review, revision, and approval of the return to work action plan by the AP and the injured worker.

The return to work action plan may be modified or adjusted during the treatment or follow-up phase as needed. At the end of the program the listed return to work action plan outcomes must be included with the treatment discharge report.

Return To Work Action Plan Roles And Responsibilities

In the development and implementation of the return to work action plan, the program counselor, the department assigned counselor, the AP, and the injured worker are involved. Their specific roles and responsibilities are listed below.

1. The program counselor:
    - **Co-develops the return to work action plan with the department assigned** counselor.
    - Presents the return to work action plan to the claim manager at the completion of the evaluation phase if the injured worker is recommended for admission for treatment and needs assistance with a return to work goal.
    - Communicates with the department assigned counselor during the treatment and follow-up phases to resolve any problems in implementing the return to work action plan.
2. The department assigned counselor:
    - Co-develops the return to work action plan with the program counselor.
    - Attends the chronic pain management program discharge conference and other conferences as needed either in person or by phone.
    - Negotiates with the AP when the initial return to work action plan is not approved in order to resolve the AP's concerns.
    - Obtains the injured worker's signature on the return to work action plan.
    - Communicates with the program counselor during the treatment and follow-up phases to resolve any problems in implementing the return to work action plan.
    - Implements the return to work action plan following the conclusion of the treatment phase.
3. The AP:
    - Reviews and approves/disapproves the initial return to work action plan within 15 days of receipt.
    - Reviews and signs the final return to work action plan at the conclusion of the treatment phase within 15 days of receipt.
    - Communicates with the department assigned counselor during the treatment and follow-up phases to resolve any issues affecting the return to work goal.
4. The injured worker:
    - Will participate in the selection of a return to work goal.
    - Wiil review and sign the final return to work action plan.
    - Will cooperate with all reasonable requests in developing and implementing the return to work action plan. Should the injured worker fail to be cooperative, the sanctions as set out in RCW 51.32.110 shall be applied.

FEES

Non-Hospital Based Programs

Description	Local Code	Duration	Fee Schedule
Pain Clinic Evaluation Phase	2010M	Conducted over 1-2 days	$1,030.16
Pain Clinic Treatment Phase	2011M	Not to exceed 18 treatment days	$659.84 per day
Pain Clinic Treatment Extension Phase	2012M	Not to exceed 10 treatment days	$659.84 per day
Pain Clinic Follow-Up Phase	2013M	Not to exceed 5 follow-up days	$283.63 per day

Hospital Based Programs

Facility based chronic pain management programs will bill using the revenue codes listed in the following table on a CMS-1450 (UB-92) form.

Description	Revenue Code	Duration	Fee Schedule
Pain Clinic Evaluation Phase	0011	Conducted over 1-2 days	$1,030.16
Pain Clinic Treatment Phase	0012	Not to exceed 18 treatment days	$659.84 per day
Pain Clinic Treatment Extension Phase	0017	Not to exceed 10 treatment days	$659.84 per day
Pain Clinic Follow-Up Phase	0013	Not to exceed 5 follow-up days	$283.63 per day

Inpatient Room And Board Fees

There are occasions when the chronic pain management program evaluation indicates a need for the injured worker to be treated on an inpatient basis. All State Fund inpatient admissions will require prior authorization and utilization review. Utilization review for the department is provided by Qualis Health. Eligible providers will contact Qualis Health at 1-800-541-2894 or fax their request to 1-877-665-0383. Qualis Health will compare the injured worker's clinical information to established criteria and make a recommendation to approve or deny the inpatient admission request to the claim manager. The claim manager will make the final authorization decision. When the claim manager authorizes treatment on an inpatient basis, the provider will be paid up to $468.53 per day for room and board costs. These costs should be billed using either Revenue Code 0129 (semi-private) or 0149 (private). This rate may be adjusted annually when the department publishes its fee schedule.

An acceptable return to work action plan is a one-page statement (see Provider Bulletin 04-15 Appendix A for sample format) included with the chronic pain management program's vocational evaluation report that contains:

- The injured worker's current vocational status with the employer of injury.
- The injured worker's current level of physical function.
- The appropriate U.S. Department of Labor Dictionary of Occupational Titles (DOT) number and physical demands of the job goal common to the immediate labor market.
- The actions, timelines, and people responsible for achieving the Return to Work Action Plan goal.

BILLING FOR PARTIAL DAYS IN TREATMENT OR FOLLOW-UP PHASES

It is expected that the injured worker will be in attendance for the full 6-8 hours each treatment day during the treatment phase. If the injured worker is unable to complete a full day of treatment due to an emergency or unforeseen circumstance, the provider should bill for that portion of the treatment day completed by the injured worker.

Example number 1: Clinic A requires the injured worker to be in attendance for 8 hours for each treatment day. The injured worker had an unforeseen emergency and had to leave the clinic after 2 hours (25% of the treatment day) on one treatment day. The clinic would bill the department for that day as follows: $659.84 x 25% = $164.96

For the follow-up phase, the provider should bill for that portion of the follow-up day that the injured worker is in attendance.

Example number 2: Clinic B scheduled the injured worker for 3 hours of follow-up services. Clinic B's normal hours of attendance for the injured worker is 6 hours. Clinic B would bill the department for those 3 hours of follow-up services as follows: $283.63 x 50% = $141.82